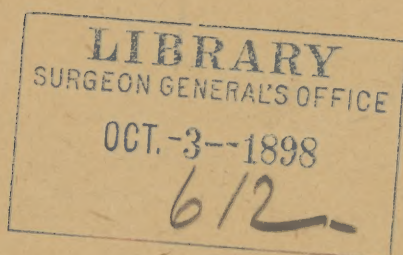


Kinloch (R.A.)

Two cases of ovariotomy

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Two Cases of Ovariectomy:

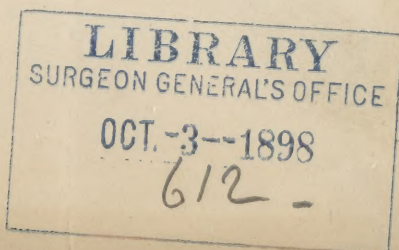
*One a Double Operation—Large Polycystic Ovarian
Growths; Ligation of Pedicles; Use of Drainage
Tube; Injection of Salicylic Acid and Borax.
Recoveries.*

BY R. A. KINLOCH, M. D.,
CHARLESTON, S. C.

[From the Charleston Medical Journal and Review, July, 1876.]

Case 1. Miss N., a native of Charleston, of Irish descent, aged 23, had been in bad health for several years. Suffering began with menstrual irregularity, and, occasionally, excessive flow. Two and a half years since began to have pain in right iliac and hypochondriac regions, with noted fulness of lower part of abdomen. Swelling of abdomen gradually became more general, and finally there was detected an irregular lobulated tumor, above and to the right of the umbilicus. My distinguished friend, Prof. E. Geddings, who formerly had charge of the patient, had diagnosticated the character of the disease. General treatment had been of no service; tapping had been done on the 9th of May, 1875, to relieve distention and embarrassed respiration; several gallons of liquid then removed.

Patient was first seen by me in November last, having determined, at the suggestion of Prof. Geddings, to have an opinion as to the question of an operation. Her general health was exceedingly bad; she was anæmic and hydropic; abdomen dis-



tended to an extreme degree; respiration difficult; digestion imperfect; menstruation absent for over a year; lower limbs œdematous to twice their natural size. To give temporary relief, and more particularly to consider the diagnosis and the chances for surgery, I tapped her on the 15th of November, removing several gallons of rather clear, yellowish fluid, which contained abundance of albumen. The walls of abdomen were much attenuated. Through these I easily discovered a large nodulated semi-fluctuating tumor, restricted in its movements, and occupying the upper and right portion of abdominal cavity, reaching close up under the liver. Upon attempting to press the tumor laterally and from above, it yielded slightly, and seemed to drag with it much thickened structure, underlying the abdominal walls. The uterus, examined *per vaginam*, did not move with the tumor, nor was it in any way displaced or enlarged.

I felt confident I had to deal with a large ovarian cystic growth, coming most likely from the *right* side. Patient's condition was considered very critical. The prognosis was certainly death without surgery, and a very doubtful chance with all the resources of our art.

Upon a conference with Prof. Geddings and Dr. F. M. Robertson, it was decided not to urge an operation; at the same time *I felt it a duty not to refuse one, if this was requested by the patient.* In the meantime, I instituted some general treatment, mostly of a hygienic kind, as preparatory to surgical interference, should this be determined on. Early in December, patient notified me of her desire to submit to operation. Just after this I was suddenly prostrated by sickness, and compelled to abandon my professional duties for two months. During my absence, my friend, Dr. F. M. Robertson, to whom patient applied early in January, tapped her now for the third time. Upon my return to business, early in February, I again took charge of the case, and instituted further preparatory treatment, regulating secretions, giving quinine and iron as blood restoratives, supervising diet and exercise. Her general health had not improved; the hydropic condition was more extreme, the debility more profound. There were no counter indications to operation, however, from the state of the kidneys or other organs, so far as I could determine. Patient was calm and resigned. I appointed Wednesday, the 14th of February, for the operation.

On the appointed day, patient was put on the table and partially etherized. The inhalation proved to be difficult, because of the extreme abdominal distention; and, after a time, the pulse failed, and there appeared signs of such great prostration, that I concluded to postpone the operation and resort simply to tapping. While patient was on table, and after some portion of the fluid had been evacuated, the girth around abdomen, across the umbilicus, measured fifty-three inches. Sufficient fluid was removed to relieve the respiration, and provide against distention for some time to come. The more solid bossilated portion of the tumor was now found to the left of the median line, and not to the right, as had been before observed. The mass was apparently fixed and pushed high up into the diaphragmatic space against the spleen. One large protuberance, more prominent than others, was felt tense and fluctuating. It was suggested to tap this separate cyst, but I refrained from so doing for fear of emptying some portion of its contents into the general cavity.

Patient soon recovered from the effects of the anæsthetic, and was removed from the table to the bed, where I proposed to keep her during further treatment. For the next twelve days she was given three grains of quinine three times a day, and a little morphine at night. Diet, milk and bread, beef-tea, and a small portion of brandy.

February 24th, gave at bed time a dose of calomel and rhubarb, to empty bowels.

February 26th, at 12½ P. M., patient was put on table, after attention to necessary details, and etherized (a little chloroform was first given) for operation. The respiration was not embarrassed as it had been the week previous, and the abdominal distention was much less. The bossilated tumor was now seen, as I had observed the day after the last tapping, to occupy a position much lower than formerly. This gave me the assurance that it was not fixed by close adhesions.

In making the usual incision below the umbilicus, so attenuated were the abdominal parieties, and so convex the surface upon which my knife bore, that with the first stroke the centre of the incision reached a depth sufficient to slightly open the cavity, and allow the escape of some of the contained fluid. After exploration with the finger and knife, I found the peritoneum just above the point opened, thickened, and adherent to the cyst wall. This connection was broken up by the finger, together with the scissors, and upon enlarging the peritoneal opening, the ascitic fluid escaped in large quantity. With a large steel sound, and afterwards with the fingers, an exploration was made, and some slight adhesions of the cyst to the peritoneum on the right side broken up. Price's large trocar was next thrust into the presenting cyst. The flow from this was not very great, and the trocar was removed as soon as it ceased. The hand now swept

entirely around the growth, which to the feel was an irregular more or less solid mass, with numerous softer protuberances, differing much in size, shape, and elasticity. This was brought forward to the abdominal opening, which now reached from the umbilicus to near the pubis. A ribbon-like expansion of the omentum stretched across the front of the tumor, and was adherent to the cyst wall. This was divided, after securing against hemorrhage by a double catgut carbolized ligature, the ends of which were cut close to the loop. After moderate traction the whole growth sprang through the parietal opening, but unfortunately not before one of the small cysts, containing gelatinous material, and what looked like partially organized structure, had been ruptured, and a portion of its contents thrown into the cavity. The tumor was found to be a large multilocular cystic growth, the secondary cysts innumerable and of varied sizes, their contents differing, too, as to viscosity and color, as is often seen in these formations. The pedicle was broad, several inches long, and came from the left side of the uterus, instead of the right, as I had been led to believe from the early history of the case. The mass, after discharge of most of the liquid contents of the cysts, weighed a little over ten pounds. The pedicle was first secured by a temporary ligature, and the tumor detached; it was afterwards flattened out, transfixed by a large needle, carrying a double catgut carbolized ligature, and secured in its two portions. The ends of the ligatures were cut off close to the knots. The cavity was carefully emptied by large soft sponges, these, after each application, cleansed by dipping them into a weak, warm solution of carbolic acid.

Because of the rupture of one of the cysts, and discharge of its contents into the peritoneal cavity, I considered it most prudent to provide for drainage, and the subsequent washing out of the cavity with an antiseptic solution. Having no drainage tube at hand, I thought it most practical to make use of a stout carbolized silk cord for this purpose. I accordingly passed the cord through a portion of the pedicle just behind the catgut ligature already applied, and brought its ends out at the lower angle of the abdominal wound. I expected the catgut ligatures to take care of themselves, and used the silk cord simply for drainage. The direct communication with the pedicle and the Douglas *cul de sac*, I considered would be sufficiently insured in this way to guide my antiseptic injections, should I determine to use such. The abdominal wound was closed with thirteen stout silver wire sutures, passed through the whole thickness of the parietes, including the peritoneum. The silk ligature passed out between the two lowest sutures. A piece of lint, saturated with carbolized oil (one part to ten) was put over the wound, and the entire abdomen covered and supported by broad strips of adhesive plaster, coming from be-

hind and crossing each other in front. Patient bore the operation so well that when about to be transferred from the table to the bed, she had as good a pulse and as placid an expression as before the beginning of our procedures. Recovery from the etherization was prompt, and, beyond slight tendency to vomiting, during the afternoon following the operation, there were no unpleasant consequences.

After treatment, first day, 6 P. M., patient had taken only a spoonful or two of milk and lime water, equal parts, with pieces of ice occasionally; had vomited a little once; pulse 112; temperature 100°; *R.* morph. sulph. $\frac{1}{4}$ grain, at night, if restless or suffering.

2d day. 9 A. M., had not required the morphine last night; pulse 120; temp. 100.1°. 7 P. M., pulse 120; temp. 100.5°; diet during day, milk and lime water in very small quantities. No medication.

3d day. 9 A. M., pulse 112; temp. 101°. 7 P. M., pulse 140; temp. 102.5°. *R.* quinine grs. iij; calomel grs. $\frac{1}{2}$; morphine gr. $\frac{1}{8}$, every 3 hours if awake. Ice in moderation.

4th day. 9 A. M., patient felt much relieved; had passed a good night; pulse 120; temp. 102.5°; *R.* continue pills of quin., cal., and morph., every 4 hours; diet, milk and lime water, with ice. 5 P. M., pulse 128; temp. 103.5°; complains of some tightness of the abdomen; slackened the adhesive plasters; continue pills; give salicylic acid, 5 grs., in alkaline solution, every 4 hours.

5th day. 9 A. M., pulse 120; temp. 101°; profuse diaphoresis; otherwise feels better; stopped pills; continue salicylic acid; diet same. 5 P. M., pulse 124; temperature 102.5°; complains of fulness of bladder; (up to this time I had preferred, contrary to general usage, to allow patient to empty bladder herself while over a bed-pan, the use of which I had got her accustomed to during the preparatory treatment. I incline to the belief that when this can be done, it is less annoying to patient, and avoids rather than increases excitement. I now, for the first time, resorted to the catheter,) salicylic acid continued.

6th day. 9 A. M., pulse 120; temp. 100.1°; used catheter. 6 P. M., pulse 130; temp. 101°; bowels spontaneously moved this P. M.; catheter used; salicylic acid continued; diet same.

7th day. 9 A. M., pulse 112; temp. 100.1°; two stools during night; passed urine naturally; slept a good deal, and feels very comfortable; still much diaphoresis and ringing in ears; examined wound and found union perfect; removed all the sutures but the lowest one, upon which the ligature rested; readjusted plasters with care; very little discharge about ligature; carbolized oil dressing. 6 $\frac{1}{2}$ P. M., pulse 112; temp. 101°; two more stools, with feeling of relief; has now "not a pain or ache anywhere"; passed urine naturally.

8th day. 11 A. M., pulse 112; temp. 100.3°; had an excellent

night; one healthy stool; allowed a spoonful of brandy once in 4 hours; silicylic acid every 6 hours. Evening, condition about the same; very little discharge from ligature.

9th day. 9 A. M., pulse 112; temp. 100°; one healthy stool; stop salicylic acid; continue brandy; diet, beef tea and milk ad libitum.

10th day. (Notes taken by Dr. Robertson, for two days, as I was absent from the city.) 10.30 A. M., pulse 120; temp. 108°; four stools since last visit; some discharge from ligature. $\mathcal{R}$. 30 drops of McMunn's elix. of opium at once; to be repeated in three hours if necessary; diet, milk and beef tea; a little brandy when feeling weak. 4½ P. M., pulse 120; temp. 103°; bowels quiet; since dose of elix. opii., discharge from ligature continues; feels more comfortable; dressing of carbolized oil as before

11th day. 9 A. M., pulse 128; temp. 102¾°; had one loose stool, with much flatus, but no pain; had taken 30 drops of the elixir; removed the last suture; discharge from ligature more laudable and in less quantity; to take elixir if necessary; stimulant and diet the same. 5½ P. M., pulse 120; temp. 100.5°; one small stool since morning; discharge the same; no pain or tenderness; had taken one dose of elixir, and relished some chicken soup.

12th day. 9 A. M., pulse 120; temp. 101.3°; free discharge from ligature, and from situation of last suture, occurred during the night after turning on the side. 5½ P. M., (I assumed charge of patient,) pulse 112; temp. 100.5°; one stool to-day; took 30 drops of the elixir. $\mathcal{R}$. quinine grs. ii, 3 times a day; elixir opii. if necessary; diet the same.

13th day. 9 A. M., pulse 116; temp. 101°; one stool during the night; took 15 drops of the elixir; good deal of dark offensive discharge from the wound; ligature came away upon very slight traction; passed a small tent to insure patulence of wound; quinine continued; diet, biscuit or bread, with milk or beef tea, or chicken soup. 6 P. M., patient comfortable; no change.

14th day. 9 A. M., pulse 112; temp. 100.3°; one stool in night; discharge diminished, and less offensive; tent renewed.

15th day. 9 A. M., pulse 112; temp. 100.1°; two natural stools; discharge more abundant; syringed wound with two per cent. solution of carbolic acid, warm; quinine continued; diet, beef steak with bread, hominy, and milk.

16th day. 11 A. M., pulse 100; temp. 100.3°; discharge improved in character, and lessened; syringed wound; treatment and diet as before.

17th day. 11 A. M., pulse 100; temp. 100.5°; feels quite strong; sat up a short time yesterday and this morning; appetite good; but little discharge; treatment and diet the same.

18th day. 12 M., pulse 92; temp. 100.3°; doing well.

19th and 20th days. Nothing worthy of note.

21st day. 11 A. M., pulse 112; temp. 102°; had restless night,

but feels better to-day; great and sudden change in weather yesterday; patient got chilled, and thinks she has taken cold; complained of ringing in ears; stop quinine, and give salicylic acid, grs. v, every four hours.

22d day. Pulse 112; temp. 102°; some tenderness in right groin, running up in direction of ascending colon; decided hardness there; no discharge from wound; *R.* pil. hyd. mass. grs. vi; ext. hyoscyamus, grs. ii, at bedtime, and a small dose of seltzer aperient in the morning; salicylic acid during the day.

23d day. 12 M., pulse 100; temp. 100°; had a good night; medicine acted gently this morning; less tenderness and hardness over cæcum; feels very well; very slight discharge; no medication; sits up and walks around room when inclined.

26th day. 12 M., pulse 100; temp. 101°; feels well; bowels have acted once since last report; slight fulness in groin remains; no discharge from wound; appetite good; *R.* citrate ferri et quiniæ, grs. v, three times a day.

June 12th, 1876. Since concluding the above record I have seen patient often, and can now report her restoration to perfect health. Menstruation, after having been absent for a year, returned first on the 9th of May. Anæmia has disappeared; complexion is florid and healthy; digestion and appetite so good that she remarked to me a few days since: "I can eat ten meals a day if I followed my inclination."

Case 2. Miss M., aged 30, native of Charleston, of Scotch descent. In good health up to April, 1874, when she began to suffer from excessive and frequent menstruation, the flow returning about once in ten days between the months of April and July following. After that, under treatment, became more regular, but there remained a continued uneasy feeling of fulness in the left side. Some swelling of the abdomen was noticed first in December, and continued without very marked increase until the next October, 1875. At this time, pain began in the right side, and swelling increased more rapidly. In January of the present year, began to suffer from indigestion, and afterwards from slight cough, with oppressed breathing. Had, during much of this period, been nervous, or had attacks of an hysterical character. Tumor was not discovered before December, 1875, and after the abdomen had become greatly distended. Was then examined and pronounced by good surgical authority in the city to have an abdominal tumor, incurable, or not eligible for operation.

First seen by me, in company with my friend Dr. Wm. M. Fitch, who had long been her physician, on the — of March. General appearance good; strength moderate, but did not admit of much exercise. Abdomen distended to a degree beyond that seen at full time of pregnancy. Suffering from

embarrassed respiration, and symptoms of sub acute gastritis; could not rest when perfectly recumbent, and vomited at times. From time to time she had also experienced mild attacks of circumscribed peritonitis. Examination of abdomen by palpation and percussion, enabled me to define accurately the limits of a large tumor, lying rather to the left side, and reaching from the groin up to the left ribs, where it encroached upon the stomach, and diaphragmatic space. Percussion gave a dull sound over most of this region, with distinct resonance down on either side, but more particularly on the right. Elasticity and fluctuation were readily appreciable over the greater part of the dull region; the upper portion of this dull region was, however, hard and irregular to the touch, and not distinctly fluctuant. Examination, *per vaginam*, discovered the uterus to be healthy and in position; it did not move from any pressure brought to bear upon the abdominal swelling.

With such a history and condition, I did not hesitate to diagnose the case as one of ovarian cystic tumor, offering a good prospect for operation. A few days afterwards, I aspirated the cyst, a few inches below the umbilicus, and obtained a gill of clear straw colored fluid, rich in albumen.

Preparatory to operation, patient was kept in bed, put upon a milk diet; took an occasional mercurial laxative, followed by mild salines to regulate the bowels; besides had bismuth with minute portions of morphine to relieve the stomach. Improvement was prompt, and I was enabled to fix an early day for the operation. Diet was more liberal as the gastric trouble was relieved. For some days prior to the operation, three grains of quinine, with an eighth of a grain of morphine were well borne, and served to increase the general tone of the system. Patient was habituated to the use of the bed-pan. A mild cathartic was given two days before the operation.

Operation. April 5th, 12½ P. M. Tested by the thermometer, while patient was on the table, the temperature was found to be 100°; anaesthesia was started with chloroform, and then fully completed with ether. Several efforts at vomiting occurred before etherization was established. This I attributed to the chloroform.

The usual incision, starting below the umbilicus, and at first very limited, with the view of exploration only, was practiced. Upon opening the peritoneum, there escaped an ounce or more of viscid, gelatinous, straw colored material, which at first led to the impression that the cyst wall had been penetrated. Slight examination, however, discovered the fact that this was fresh plastic exudation from an inflamed peritoneum. Upon inspection, there was seen distinct traces of bloody extravasation between the serous membrane and the loose adjacent tissue. This was evidently the result of the explorative tapping, done ten days before. After the free opening of the peritoneum there

drained away two gallons or more of ascitic fluid. The large steel sound now introduced through the wound, discovered no serious adhesions, so I next enlarged the abdominal opening with the scissors, to the extent of six or seven inches, and passed my hand and arm entirely around the tumor, ascertaining fully the possibility of its removal, and at the same time breaking up some few adhesions of an unimportant character. The small trocar thrust into a presenting cyst soon emptied this; it proved to be quite small, and contained a clear yellowish fluid, such as I had obtained by my preliminary aspiration. Price's large trocar was now thrust deeper at another fluctuating point, but with the result of evacuating only a second small cyst, containing a grumous chocolate colored fluid. The bulk of the tumor had, by these operations, been but little reduced. I next made an effort to reach larger cysts, discovered to be more deeply seated, by urging the trocar to a greater depth. I was disappointed in this effort, only liberating some thick colloid-looking material, with shreds of semi-solid matter, which it was difficult to prevent escaping into the general cavity. To facilitate manipulation, I now further enlarged the abdominal wound, extending it upwards with the scissors, above and to the left of the umbilicus. This gave me full command of the growth. The left hand was passed under it, high up in the diaphragmatic space, and made it revolve upon its axis, so as to bring the deep surface forward to the abdominal opening. There now presented what seemed to be the main or primary cyst, which was exceedingly tense and elastic. Some time had been lost, and fearing that delay would jeopardize my patient, I resolved to violate rule, in order more quickly to terminate the operation. While the left hand, still under the tumor, pressed it forward to the abdominal opening, and held it securely there, the right plunged the scalpel deeply into the large cyst, and emptied it in a trice. The tension under which the fluid had been kept was so great, that upon the entrance of the knife, one of my assistants was deluged by the impetuous gush of what, fortunately for him, was only limpid, serous fluid. My object was now fully realized. The mass sprang readily forward, and was at once extracted. The pedicle was shorter than in the previous case, but, like it, came from the left side. It was transfixed and tied in halves with a carbolyzed silk ligature. The ends of one ligature were cut close, those of the other were retained and brought out at the lower angle of the wound. Pathologically, the growth was almost the counterpart of the previous one. There was, too, but little difference in their weights; this one, after emptying all the large cysts, being a fraction under ten pounds.

The right ovary was now examined, found enlarged, and presenting an early stage of the same kind of disease. The numerous small cysts varied in size from the head of a large pin, to that of a large pea. The pedicle was here again transfixed and ligated in halves; both ends of the ligatures were cut close.

The cavity was carefully sponged, as described in the previous case. It was with difficulty that my careful assistants prevented the intestines from protruding during my efforts to thoroughly empty the Douglas *cul de sac*. Before closing the wound, I applied a fine carbolized silk ligature to a small vessel that was seen bleeding near the ligature that held one portion of the pedicle on the left side. Twelve stout silver wire sutures were now passed. Between the two lowest sutures I directed the ends of the ligature from the left pedicle, and, determining to use one of Thomas' glass drainage tubes, I carried these ends through the tube, and, finally, pushed this latter gently down to the Douglas *cul de sac*. A little roll of muslin, affixed to the ends of the ligature, rested upon the rim of the tube, and prevented the ends of the threads from falling into the cavity. A compress of lint saturated with carbolized oil, and the broad adhesive straps over this, completed the dressing. The rim of the tube came through an opening in one of the adhesive straps, and over this a separate piece of oiled lint was loosely placed, and pinned to the plaster. Patient was quickly dressed and got ready for bed. She was suffering so much from shock that I injected hypodermically into each arm a drachm of good whisky; then put her to bed, and applied warmth in the usual way.

4 o'clock, P. M., reaction fully established; patient had vomited several times a little aqueous fluid; $\mathcal{R}$. morph. sulph. gr. $\frac{1}{4}$, hypodermically; a teaspoonful of milk and lime water occasionally; ice. 10 P. M., pulse 120; temp. 100.1°; vomited once since last visit; now quiet; passed urine naturally in bed-pan; bandages and linen saturated with fluid that had exuded through the tube while patient yet remained supine; repeated morphine.

2d day. 9 A. M., pulse 120; temp. 100.1°; slept a little during the night; vomited once; took milk and lime water several times; more fluid had escaped through the tube; passed urine. 1 P. M., pulse 120; temp. 99.5°; vomited once a little greenish fluid. 6 P. M., pulse 120; temp. 100°; vomited once more; a small portion of a two per cent. solution of salicylic acid and borax, warm, was squeezed from a sponge into the tube. 10 P. M., pulse 120; temp. 100.5°; had been generally quiet; vomited once, little greenish fluid; eructated some gas; salicylic acid solution thrown into tube; diet, milk and lime water; ice.

3d day. 9 A. M., pulse 96; temp. 100.1°; had a good night; slept very well; no vomiting; thirst not so great as yesterday; face flushed; but feels no pain or discomfort; injected the cavity gently with salicylic acid solution from a Mattson's syringe; the liquid passed out of tube in a recurrent stream, unchanged in appearance; it evidently did not diffuse itself in the cavity, but reached the pedicle or the retro-uterine sack, and then returned. 5½ P. M., pulse 94; temp. 100.1°; had a quiet and comfortable day; took milk and lime water freely; less eructation; flatus escaped by anus; menstrual discharge appeared to-day, ten days

in advance of time; injected through tube as before; liquid returned slightly turbid.

4th day. 9 A. M., pulse 100; temp. 101°; had a good night; slept well and felt refreshed; syringed through tube; liquid returns more turbid than yesterday. 5 P. M., pulse 86; temp. 100°; syringed again; diet, same.

5th day. 9 A. M., pulse 100; temp. 99°; slept very well last night; injected salicylic acid; return liquid had a little odor; diet, arrowroot and gelatine, with milk. 6 P. M., pulse 90; temp. 99.5°; very good day, but troubled some with flatus; injected salicylic acid; diet same.

6th day. 9 A. M., pulse 96; temp. 102°; troubled some with flatus during night; at 12 M. took a pill of quinine grs. ii, morphia gr. $\frac{1}{4}$, that had been directed conditionally; injected tube; diet same. 6 P. M., pulse 98; temp. 100°; uncomfortable from much flatus; just had a small stool, with much straining and some tenesmus of rectum and bladder; ordered at once a warm water enema, and elix. opii. gtt. x; Hoffman's anodyne, gtt. v, in a spoonful of mint water; to be repeated once in two or three hours, if suffering.

7th day. 9 A. M., pulse 120; temp. 101°; had another movement of bowels after the enema; took two doses of the elixir with mint water; had a rather comfortable night and feels very well this morning; menstrual discharge, which had been slight, ceased entirely yesterday; some odor from tube; slight suppuration from the parietal wound just at the tube; removed most of the wire sutures; wound appeared to have united well, except a limited portion of the cutaneous margin which had been somewhat inverted; syringed out tube; elix. opii. and mint water if necessary; diet, beef tea, milk, and biscuit. 6 P. M., pulse 112; temp. 100.5°; had quiet day; not annoyed with flatus; syringed out tube; medication and diet same.

8th day. 9 A. M., pulse 100; temp. 100.5°; had best night since operation; wound discharging some laudable pus at site of tube; some offensive odor; syringed as usual; return fluid quite turbid; ether and opium mixture if necessary; diet same. 6 P. M., pulse 104; temp. 102°; some suppuration; odor more offensive; return liquid contains more pus; had taken one dose of mixture for flatus.

9th day. 9 A. M., pulse 104; temp. 100.5°; comfortable night, after 1 o'clock; discharge slight, and laudable; treatment and diet same; removed three wire sutures. 6 P. M., pulse 104; temp. 101.5°; no complaint; takes plenty of nourishment; slight discharge; odor rather offensive; syringed as usual.

10th day. 9 A. M., pulse 96; temp. 99°; feels remarkably well; less discharge; no odor from tube; syringed as before; diet, beefsteak allowed. 6 P. M., pulse 104; temp. 101°; feels well; took beefsteak with relish; injected tube.

11th day. 9 A. M., pulse 100; temp 100°; expresses herself as feeling so well as to have forgotten she had undergone an operation; a warm enema had just given free action of the bowels, and this had quickened pulse; syringed tube; the return current brought with it several small sloughs, and one ribbon-like piece three inches long. 7 P. M., pulse 96; temp. 100°; syringed tube; no discharge or odor perceptible.

12th day. 9 A. M., pulse 96; temp. 100°; slept nearly all night. This morning feels "awful hungry;" removed the tube to clean it, as I noticed it to be encrusted with a yellowish deposit; found upon injecting the wound that the fluid returned as readily as it had done through the tube; I, therefore, did not replace this; took out another one of the wire sutures, which left only one remaining just above the opening that had been occupied by the tube. 6½ P. M., pulse 94; temp. 100°; excellent day; no discharge from wound; syringed as usual.

13th day. 9 A. M., pulse 96; temp. 99.5°; had an enema of warm soap suds this morning, which had not yet acted; injected as usual. 6 P. M., pulse 96; temp. 102°; enema had given two constipated stools; patient now comfortable; had taken beef steak with rice for dinner; syringed wound, but noticed no discharge.

14th day. 9 A. M., pulse 94; temp. 101°; had very good night; only a little annoyed with flatus; took a dose of the ether and elix. opii.; complains of slight soreness over right ovarian region, running up to anterior superior spinous process of ilium; injected wound. 12 M., summoned to see patient; had increased pain in right ovarian region, or rather, as appeared, about the cœcum, running up the ascending colon as far as the ribs; this increased upon inspiration. Looks anxious and distressed; abdomen, in region noted, rather tender upon pressure; pulse quickened to 120. *R.* calomel and quinine each grs. ij, opium gr. i, in pill No. 1, every three hours; diet restricted to milk. 6 P. M., pulse 108; temp. 101°; feels rather better, but still has the symptoms of the morning in a less degree; had taken two of the pills; ordered these to be continued every four or five hours; milk diet.

15th day. Pulse 100; temp. 100°; had taken two pills during the night and slept off and on. At 6 o'clock this morning vomited a little bile mixed with milk; vomited again at 8 o'clock; wound discharging more than it had done for two days past; ligature came away upon slight traction, bringing with it a piece of dead tissue half an inch long and as thick as a small goose quill; the tenderness of the abdomen had subsided; syringed wound; stop pills and take mixture of ether and elix. opii. if in pain; diet, milk with arrowroot and gelatine. 6 P. M., pulse 104; temp. 103°; face flushed; looks depressed; has been annoyed with flatus, and pain in right side of abdomen; feels rather weak; had taken one dose of the mixture since morning;

R. a dessertspoonful of brandy every three hours; continue mixture if suffering; milk diet.

16th day. 9 A. M., pulse 92; temp. 101°; slept about half the night; had inclination to stool early this morning; took warm enema and had a fecal stool; was also relieved of much flatus; still looks anxious, and has some tenderness over right ovarian region which is increased by extending the right thigh; no general distention of abdomen; removed last suture; syringed wound; same treatment, and diet with a little brandy several times a day. 6 P. M., pulse 104; temp. 102.5°; face a little flushed and anxious, but feels better; slight discharge from wound; no decided tenderness in right groin; syringed wound; same treatment and diet.

17th day. 9 A. M., pulse 104; temperature 101°; slept well; has no pain; no discharge from wound; syringed as usual; same treatment and diet. 6½ P. M., pulse 112; temp. 102.5°; return current from wound more opaque; same treatment and diet.

18th day. 9 A. M., pulse 100; temp. 100°; had a better night; slept without medicine; has no pain; but little discharge; syringed wound; diet, milk with arrowroot and gelatine, beef tea. 6½ P. M., pulse 112; temp. 101.5°; very good day, but troubled with flatus; complains of heat of weather; took two doses of the mixture. *R.* quinine, opium, and blue mass, each two grains every eight hours; same diet.

19th day. 9 A. M., pulse 112; temp. 102°; did not sleep much, but feels better to-day; very little discharge; syringed wound; bowels to be moved by enema; continue pills; same diet.

20th day. Pulse 92; temp. 99.5°; had good night; bowels freely moved yesterday by the enema; feels quite well; discharge from wound increased; upon sponging, noticed that the nozzle of the syringe was raised up whenever the least quantity of fluid was thrown in; stop the blue mass; continue quinine and opium pill every eight hours, if annoyed by flatus.

21st day. 10 A. M., pulse 100; temp. 100°; no complaint; discharge very slight; nozzle of syringe thrown up forcibly when injecting; seems to be lifted by some elastic body as the fluid goes in; diet, milk, biscuit, hominy, beef tea.

22d day. 9 A. M., pulse 98; temp. 101°; last evening had a good deal of pain in left groin; vomited; felt straining upon the rectum; took dose of ether and opium mixture; also had a warm enema, when relief followed; this morning feels well; there is a good deal of healthy discharge from wound; the pain of the evening was evidently from retention of purulent secretion; to take pill of quinine and opium only twice a day; syringed wound; diet same. 7 P. M., pulse 100; temp. 101°; had some pain to-day; also vomited once; now comfortable.

23d day. 10 A. M., pulse 92; temp. 101°; had good night; but little appetite this morning; discharge lessened; enema

ordered to move bowels; syringed wound; stop pills. *R.* sul. morph., grs. ij; aquæ camphoræ ℥ ij; M.; to take a teaspoonful occasionally, if in pain from flatus; diet same.

24th day. 10 A. M., pulse 100; temp. 102°; had good night, but vomited this morning; no discharge from wound; feels fullness about abdomen. *R.* pil. hydr. mass., grs. vi, ext. hyoseyamus, gr. i, in pill No. 1. Take this morning, and follow it in three hours by a dose of seltzer aperient; milk diet.

25th day. 10 A. M., pulse 100; temp. 101°; excellent night; bowels moved freely yesterday; wound discharging healthy pus; diet, beef tea, hominy, eggs, and milk.

26th day. 9 A. M., pulse 96; temp. 100°; good night; bowels moved twice since last visit; wound discharging healthy pus; syringed as before.

27th day. 10 A. M., pulse 96; temp. 100°; feels well; healthy discharge; appetite excellent; sat up yesterday out of bed.

28th day. 10 A. M., pulse 96; temp. 100°; healthy discharge; syringed wound; patient walked a little to-day; bowels to be moved to-day by enema.

29th day. 11 A. M., pulse 88; temp. 99.5°; discharge much less; troubled a little with flatus; walked some; syringed wound.

30th day. 9 A. M., pulse 88; temp. 98°; bowels moved this morning by seltzer aperient; gaining strength rapidly; no discharge of consequence.

31st day. 9 A. M., pulse 88; temp. 98°.

32d day. 9 A. M., pulse 86; temp. 98°.

33d day. 11 A. M., pulse 72; temp. 98°; walked into next room yesterday, and has nothing to complain of.

June 12th, 1876. Patient has daily improved since last report, and is now in perfect health. It is interesting to record the fact that menstruation has not appeared since the period, if it can be called such, that commenced on the third day after the operation, and lasted four days. This discharge may have been the result of mere congestion set up in the uterus from the close relation of the organ to the parts removed by operation; or it may have been the necessary and consequent phenomenon of a functional activity of the parts removed, which had been initiated prior to their excision.

Remarks.—It will be noticed that in the above cases we not only had a test of the value of ligatures of different materials, but that these were employed after distinct methods. Carbolic catgut was used in the first operation, and the ends of the ligature cut off close to the loop, this being left to become encysted or undergo absorption. In the second operation, silk was the material employed. With the right pedicle the loop was left to be encysted. With the left, this was practiced only with one half of the pedicle, the ligature of the other half being brought out of the wound.

This application of distinct methods was not a matter of experiment merely. Originally, and as the result of a careful consideration of the experience of the best operators, I was inclined to the belief, that with silk, as well as catgut ligatures, it was best to leave the loop to take care of itself, *rather than risk keeping open the cavity*. Without wishing to generalize from a small experience, I am, nevertheless, now disposed to regard the so-called open treatment, or the use of the ligature after the original method of McDowell, as offering the best chance for success in certain grave cases of this operation.

The ligature thus used, insures a certain degree of drainage. If made antiseptic, it can hardly act as a local irritant to tissues with which it remains in contact. It is, besides, incorrect to affirm that the ligature *keeps open* the peritoneal cavity. If it be properly managed it takes a tolerably direct route from the pedicle and the Douglas *cul de sac*, outwards; and its presence, together with the necessary inflammatory or nutritive changes of the first forty-eight hours, establishes a track that is independent, and, as it were, *outside* of the general cavity. By means of this tubular wound then escapes the materials, liquid or solid, the retention of which would seal the fate of the sufferer. By this channel also may we expect, by the aid of cleansing or antiseptic injections, to assist the natural efforts by which inflammatory products reach the surface.

What is here attributed for the ligature, may with greater reason be assigned to the drainage tube. If the former has the advantage of occupying less space, the latter is certainly superior as a means of drainage, and as an efficient instrument wherewith to introduce our cleansing injections. The calibre of the tube allows solid particles, or effete products, to pass readily, gases to escape promptly, and, as we saw in the clinical history of our second case, even large pieces of gangrenous structure to be removed with ease. It is most certainly true that many cases of ovariectomy require no provision for drainage. But can these be invariably recognized? Does it not require an extensive experience in such operations to say when life is, or is not, to be threatened by the detention of exudations or inflammatory products? Is it not a safer rule to give all cases the benefit of a doubt when we have once ascertained that the use of a ligature, or of a tube, is generally well borne? If a drop of pus is detained under the quickly formed scab of a trifling superficial wound, how soon does the pain and throbbing indicate the trouble, and how soon does not relief come with the escape of the inflammatory product? Our above clinical report shows that upon several occasions the general condition of our patients gave evidence of this retention in the track of the deep wound. To what extent would this danger not have increased, had the warnings for relief been disregarded? I am firm in my conviction that the retention of the peritoneal serous exudation, that during the first twenty-four

hours escaped through the tube in case No. 2, would have proved adverse to recovery. And what shall be said of the consequences that would have ensued had the portions of gangrenous tissue not found ready exit? It may be said by some that the presence of the tube developed such inflammatory products. I cannot admit such a conclusion in view of the abundant evidence given by Professors Peaslee, Thomas, and others, of the tube being generally well borne.

I feel much indebted to Prof. Thomas for the pattern of the glass tube that did such good service. I would simply suggest that the rim of the tube be notched upon one side, to indicate clearly its position when in situ. I found it at times disposed to turn half round. And where it is removed, from time to time, to be cleansed, it is important to keep in mind the direction of its curve, as it is reintroduced.

Prof. Thomas thinks it important that the end of the tube should pass well down into the Douglas *cul de sac*, and hence he uses tubes of varied length and curve, as well as calibre. In my case, it is possible that the passing of the ligature through the tube may have militated against this principle, which appears so correct, and caused the tube to rest upon the pedicle. I would suggest, however, that the ligature was not kept tense, and that if the Douglas *cul de sac* be, after ovariectomy, an open receptacle, (which we are inclined practically to question) it was most certainly drained by the tube, and cleansed by the injections, notwithstanding the position of the ligature.

Other interesting questions are: Is it necessary to employ antiseptic injections at all? And how far are we warranted in injecting *in anticipation* of certain dreaded consequences of the operation?

As certain antiseptic materials are scarcely more irritating than pure water, or weak saline solutions, I thought it well to make use of them. But practically, I incline to the belief that the great object in view can be readily accomplished by the simple emptying, or washing out, of the cavity, (or, as I prefer to say, the track of the wound, not believing that the injected material is, as a rule, thrown into the cavity) twice in the twenty-four hours. Salicylic acid was selected because believed to be unirritating; while borax was used to increase the solubility of the acid, and because it also possesses known antiseptic qualities.

Regarding the other important question—the time for beginning the use of injections in such cases, I am clear in my conviction that they *should be used early, and before the appearance of septic symptoms*. We may, it is true, in following this rule, use the means unnecessarily in many cases; but we avoid the risk of using it too late. We question if the use of proper injections often develop peritonitis. It is bad surgery to neglect a wound until symptoms of septicæmia appear. It is good

surgery to care for the wound and prevent the more serious consequences. But I would be understood as advocating this course only in grave cases, and where we have reason to believe that exudations or organic materials of any kind have been left in the cavity, or will most probably get there. In my first case I feared the consequences of the ruptured cyst containing the products described. I apprehended the worst consequences in both cases, from material that had possibly escaped even my most careful sponging of the cavity. And when I noticed for hours after the second operation how much exudation passed spontaneously through the tube, I took it for granted that there was room for much of this in the Douglas pouch. Drainage of this pouch I now feel sure can be effected as well by the tube, and through the wound, as by the vagina, and certainly with less discomfort to the sufferer. The drainage tube I regard as one of the greatest advances in ovariectomy, and believe it can be successfully used in many abdominal wounds.

ART. IV.—*Gastro-Hysterotomy*.—*Removal of the Uterus, Fallopian Tubes and Ovaries*.—*Death on eighteenth day—with remarks*. By E. MILLER, M. D., Florence, S. C.

On January 10th, 1876, Abram McIver, of Darlington, S. C., brought his wife to consult me for a tumor of the abdomen, accompanied with constant pain, almost total want of rest at night, and continual inability to pass urine without putting the hands under the tumor, and drawing it up by alternate movements. The bowels were constipated, menses regular, but painful, indeed her sufferings were greatly aggravated at these times, and she had to resort to anodynes for relief. Her age is forty-two years, she is the mother of four children, the oldest twenty-nine years, the youngest twenty years. Since the birth of the last she has not had good health, nor has she been pregnant since.

The outline of the tumor could be felt in the right iliac region, as high as the umbilicus, and extended down to the pelvis, to which it seemed bound by adhesions; a depression was felt through the abdominal walls, about the middle of the tumor, from which point it was movable, as if attached by a short pedicle; no adhesions could be detected from this pedicular portion toward the free end of the tumor, which was situated near the ribs, on the right side.

Vaginal examination revealed the os high up, barely perceptible with the index finger, but giving no unusual signs to the touch; continuous profuse leucorrhœa prevailed. Simpson's sound only entered one and three-fourths inches.

At a consultation with Drs. Player, Norment, and Lunney, the sound was subsequently passed one and three-fourths inches into the uterus (as far as it seemed possible for it to go without violence); on making external manipulation of the tumor, both the pelvic and abdominal portions gave no movement to the handle of the sound, between the woman's thighs. The sound was next introduced into the bladder, and the same manipulations resorted to, with a view of learning of the existence of adhesions in that direction, with a negative result. Percussion revealed a solid tumor, the size and position of which mechanically obstructed the bladder and rectum.

The diagnosis, after three examinations, was a fibroid tumor of the ovary, with uterine or pelvic adhesions; and we so advised the patient and her friends.

We explained the hopelessness of medical treatment, and the dangerous nature of its removal by a surgical operation, and carefully avoided recommending her to submit to surgical interference, but advised her to consult her friends, before making up her mind.

She was, however, determined to have it performed, and was disappointed when we appointed the 23d of February, as she wanted it done at once. The time selected was in the middle of the month after her menstrual period, for obvious reasons; she was directed to attend to her digestive functions and a suitable diet was ordered.

On February the 23d, the patient having only taken a little tea in the morning, and the room having been heated, by my instructions, to about 70° Fah., and having prepared the table with blankets, and with reference to a good light, with tubs of hot and cold water at hand, carbolized catgut ligatures, silver wire, and carbolized sponges, she put on a pair of flannel drawers, and got on the table, with her feet towards the window.

The following physicians were present: Drs. Player, Norment, Lunney, and Boyd, as assistants; Dr. Dargan, as spectator.

Dr. Boyd gave chloroform, (it took about fifteen minutes to bring her under its influence,) and Drs. Norment and Lunney having put the skin upon the stretch, I made an incision from near the umbilicus to the pubes through the muscles and fascia, and after waiting until all bleeding had ceased, the director was pushed through the peritoneal membrane, and the incision into the abdominal cavity was completed.

The tumor came now in view, and began to protrude through the incision, I seized it with the hands, and upon raising it up found that it was a solid growth, intimately connected with the womb of a nodulated character; and to use the apt expression of Dr. Norment, resembled an immense artichoke. I now propounded the question: Should we return it to the abdomen, and desist from further operative proceedings? for it was evident that it was impossible to remove the tumor without including the body of

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